

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23-2

02737

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Charles
City or town..... La Plata
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 10 minutes

Hospital, Institution, or street address where death occurred:

Physicians Memorial Hospital
How long in hospital or institution?..... 10 minutes

3. (a) FULL NAME

Wilmer F. Butler

4. Sex..... Male 5. Color or race..... Negro 6. (a) Single, married, widowed, or divorced..... Married

6. (b) Name of husband or wife..... ANNIE Butler

7. Birth date of deceased (mo. day, yr.)..... MARCH 22 1895-
(If alive, give age..... 45 years)

8. AGE: Years..... 51 Months..... 52 Days..... 11 If less than one day..... 13 hrs. min.

9. Birthplace..... Charles Co. (Town, county, and state)

10. Usual occupation..... WATERMAN

11. Industry or business..... OYSTERING & FISHING

MOTHER FATHER 12. Name..... John F. Butler

13. Birthplace..... Charles Co. Md.

14. Maiden name..... SARAH THOMAS

15. Birthplace..... Charles Co. Md.

16. Informant..... ANNIE Butler (Wife)

Address..... Benedict MD

17. Burial..... Burial Date thereof..... 3-11-47
(Burial, cremation, or removal. Which?) Date (month) (day) (year)

Cemetery or crematory..... ARLINGTON NAT'L CEMETERY

Location..... ARLINGTON VA-

18. Funeral director..... FLIMER M. Quade

Address..... Hughesville MD

19. (Date rec'd by registrar)..... 19..... Registrar.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn Infants give residence of mother)

State..... MD..... County..... Charles

City or town..... Benedict
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

2.(a) If veteran, name war..... W.W. I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 7, 1947, at 6:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 7, 1947, to 1947

and that I last saw him alive on March 7, 1947

Immediate cause of death

Cerebral hemorrhage

Due to

Essential hypertension

10 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... James F. MacKenna, M.D.

M.D. or other

Address..... La Plata, Md. Date signed..... 3-7-47



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02738

CERTIFICATE OF DEATH *170c*

Reg. Dist. No. 100

1. PLACE OF DEATH:

County..... Charles

City or town..... Mr. Pisgah

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

State Rd. Md. 484

How long in hospital or institution?

3. (a) FULL NAME

Columbus J. Collins, Jr.

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Negro

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 15, 1910

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

35 9 15

hrs. min.

9. Birthplace

McConchie, Md.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

12. Name

Columbus Collins

13. Birthplace

La Plata, Md.

14. Maiden name

Cora Gillen

15. Birthplace

La Plata, Md.

16. Informant

Columbus Collins

Address

McConchie, Md.

17. Burial

Date thereof..... 4/2/47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

McConchie, Md.

Location

Hunt & Ryan

18. Funeral director

Wadley, Md.

Address

Julia H. Posey

19. 4-2-47

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County..... Charles

City or town..... Mr. Pisgah

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION *about*

20. DATE OF DEATH

March 30

1947, 11 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

on March 31, 1947, to

and that I ~~saw~~ saw him ~~in~~ ~~after~~ on March 31, 1947.

Immediate cause of death

Crushed chest

Due to..... Auto accident

Due to..... Struck by hit-and-run driver

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of..... 3-30-47

Where did injury occur? Mr. Pisgah, Charles, Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) State road, Rd 484Means of injury hit by auto Injured at work? No

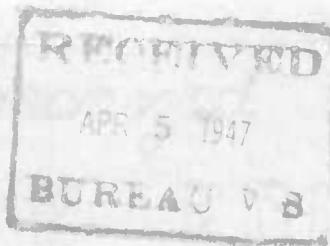
23. SIGNATURE

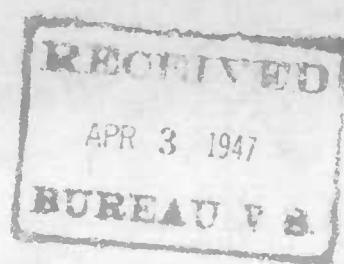
John L. McFarland, M.D., M. D. or other

Address

McConchie, Md.

Date signed 3-31-47





MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

02740
1000
Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

Charles

City or town.....

La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

James Dyer

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Negro

Widowed

6. (b) Name of husband or wife.....

Gertrude Lyles Dyer

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

?

8. AGE:

Years

Months

Days

If less than one day

.hrs. .min.

52.54

JFM

9. Birthplace.....

(Town, county, and state)

La Plata, Md.

10. Usual occupation.....

Laborer

11. Industry or business

FATHER

12. Name.....

Joseph Dyer

13. Birthplace

Chas. Co. Md.

MOTHER

14. Maiden name.....

Susan Watts

15. Birthplace

Chas. Co. Md.

Gus Watts

16. Informant.....

Address

La Plata, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... 3/14/47

(month) (day) (year)

Sacred Heart

Cemetery or crematory.....

La Plata, Md.

Location.....

Nunn & Ryan

18. Funeral director.....

Waldorf, Md.

Address

19. 3-13

(Date rec'd by registrar)

1947

Julie H. Prey

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md

County..... Charles

City or town..... La Plata

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... March 11, 1947, at 7⁵⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 3, 1947, to March 11, 1947,

and that I last saw him alive on March 3, 1947.

Immediate cause of death.....

Pulmonary tuberculosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... X Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

James L. MacKearney, M.D.

M. D. or other

Address.....

La Plata, Md.

Date signed 3-11-47

RECEIVED

MAR 15 1947

BUREAU F.B.I.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4

CERTIFICATE OF DEATH

Reg. Dist. No. 106

12741
106

1. PLACE OF DEATH:

County

City or town

Charles
Indian Head

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3 years (Winters only)

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

David Wolf Eaton

4. Sex

5. Color or race

Male

White

6. (a) Single, married, widowed, or divorced

Widowed.

6. (b) Name of husband or wife

Nora L. Eaton

7. Birth date of deceased (mo., day, yr.)

March 7, 1862

6. (c) If alive, give age years

8. AGE:

Years
85Months
1Days
1

If less than one day

hrs. min.

9. Birthplace

Kittanning Penna

(Town, county, and state)

10. Usual occupation

Civil Engineer (Retired)

11. Industry or business

U.S. Govt.

12. Name

John Eaton

13. Birthplace

Kittanning Penna

14. Maiden name

Jane Peart

15. Birthplace

Kittanning Penna

16. Informant

Mrs. Sue Eaton West

Address

Indian Head. Md.

17. Burial

Date thereof

March 9, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Oak Grove Cemetery

Location

Oak Grove, Md.

18. Funeral director

Hunt. Ray

Address

Waldorf, Md.

19. Date rec'd by registrar

3/8

1947

Odey Price

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn, infants give residence of mother)

State Virginia County West Maryland

City or town Oak Grove

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 8 1947 a.m. 8:35 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/15 1947 to 3/8 1947

and that I last saw him alive on March 8 1947

Immediate cause of death

Coronary Thrombosis

Due to

Due to

Other conditions Diabetes Mellitus

8 years

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

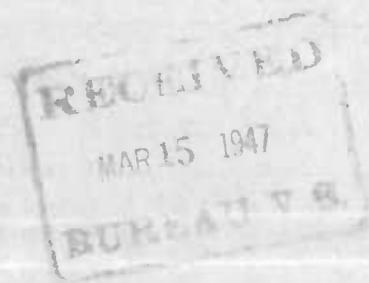
Injured at work?

23. SIGNATURE

John G. Johnson

M. D. or other

Date signed 3/8/47





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3rd

02742

CERTIFICATE OF DEATH

Reg. Dist. No. 1060

1. PLACE OF DEATH:

County

City or town

Indian Head

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Fannie Chandler Jackson

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

White

Widowed.

6.(b) Name of husband or wife

Frank Jackson

7. Birth date of deceased (mo., day, yr.)

May 24 1870

6.(c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Charles County, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Samuel Todd Chandler.

MOTHER FATHER

12. Name

Virginia

13. Birthplace

Virginia

14. Maiden name

Jane Elizabeth Todd.

Virginia

15. Birthplace

Virginia

16. Informant

Mrs. Richard St. John

Address

Indian Head

17. Burial

Date thereof: March 9 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Durham Parish

Location

Townsides Md.

18. Funeral director

Hunt & Ryan

Address

Waldorf, Md.

19. Date rec'd by registrar

May 8 1947

(Date rec'd by registrar)

Odey Price

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

Md

County

Charles

City or town

Indian Head

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name w/

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 6 1947 at 3 15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 23 1946 to March 6 1947

and that I last saw her alive on March 6 1947

Immediate cause of death

Chronic org. & cl. dis.

DURATION

2 years

Due to

Due to

Other conditions: Pernicious Anemia

1 year

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

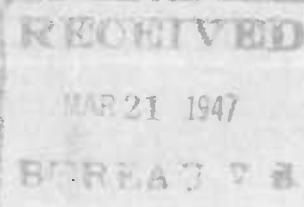
Frank G. Susan Wad

M. D. or other

Address: Indian Head, Md.

3-6-47

Date signed



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-M

02743

Reg. Dist. No. 100

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Charles

County.....
City or town.....

Bryantown

(If outside city or town limits, write RURAL and give nearest town)

5 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

WILLIAM WATT JENKINS

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed

6. (b) Name of husband or wife	Lula A. Jenkins	
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7. Birth date of deceased (mo., day, yr.)	6. (c) If alive, give age years		
Jan. 3 1873			

8. AGE:	Years	Months	Days	If less than one day
	74	2	24	hrs. min.

9. Birthplace	Charles Co. Md.
(Town, county, and state)	

10. Usual occupation	Farmer
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11. Industry or business

MOTHER FATHER	12. Name	Luther Jenkins
	13. Birthplace	Charles Co., Md

14. Maiden name	Mary Freeman
	Charles Co. Md

15. Birthplace	Leo Jenkins
Address	Bryantown, Md

16. Informant	3-31-47
Address	Date thereof (month) (day) (year)

17. Burial (Burial, cremation, or removal. Which?)	St. Mary's Cemetery
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Location	Bryantown, Md.
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18. Funeral director	Elmer M. Quade
Address	Hughesville, Md.

19. Date rec'd by registrar	19.47	Julia H. Pacey
(Date rec'd by registrar)		Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Charles

City or town Bryantown

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1947 at 5.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 march 1947 to 23 March 1947

and that I last saw him alive on the 23 March 1947

Immediate cause of death Heart Failure

DURATION

Due to Aortic and Mitral Valve

Insufficiency (2) Severe Anemia

Due to Cancer of Gastro-Intestinal Tract

Other conditions Old tuberculous case

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Francis J. Cullen M. D. or other

Address Hughesville, Md. Date signed 3/28/47

RECEIVED

MAR 31 1947

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02744

CERTIFICATE OF DEATH

Be Reg. Dist. No. 100

1. PLACE OF DEATH: Charles
 County: La Plata
 City or town: La Plata
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? _____
 Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: Md. County: Calvert
 City or town: Baltimore
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1503 Belt St.
 (If rural, give LOCATION)

2.(a) If veteran, name war: _____

3. (a) FULL NAME Gustav Kroft

4. Sex <u>M.</u>	5. Color or race <u>W.</u>	6.(a) Single, married, widowed, or divorced <u>Widowed</u>
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8.(b) Name of husband or wife: _____

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1894 6 years

8. AGE: Years 72 Months 6 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Bailes Maker

11. Industry or business: unknown

MOTHER FATHER
12. Name: unknown

13. Birthplace: unknown

14. Maiden name: unknown

15. Birthplace: unknown

16. Informant: Mrs Louise Conley

Address: 1503 Belt. St. Baltimore, Md.

17. Burial Date thereof: 3/3/47 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Brookland, Md.

18. Funeral director: Hunt & Ryan

Address: Waugh, Md.

19. Date rec'd by registrar: 3/1/47 19.47 Date signed: 3-1-47

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-1-1947 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-28 1947, to 3-1 1947

and that I last saw him alive on 2-28 1947

Immediate cause of death: Paroxysmal thrombosis

Due to: unknown

Due to: unknown

Other conditions: unknown

(Include pregnancy within 8 months of death)

Major findings of operations: unknown

Date of op.: unknown

Autopsy results: unknown

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury: unknown Injured at work? _____

23. SIGNATURE: Hedley M. J.

M. D. or other: unknown

Address: La Plata, Md.

Date signed: 3-1-47



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

02745

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH:

County CHARLES

City or town INDIAN HEAD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 YEARS

Hospital, Institution, or street address where death occurred:

12 EARL ROAD

How long in hospital or institution? 6 MONTHS

3. (a) FULL NAME

GRACE V. LYNN

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

WAYNE B. LYNN

7. Birth date of deceased (mo., day, yr.)

2-3-92

6. (c) If alive, give age 57 years

8. AGE:

Years 54

Months 1

Days 5

If less than one day

hrs. min.

9. Birthplace ALEXANDRIA, VIRGINIA

(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name CHARLES SCHREINER

13. Birthplace BALTIMORE MARYLAND

14. Maiden name STELLA HEISLEY

15. Birthplace ALEXANDRIA VA.

16. Informant H. C. MILLER

Address INDIAN HEAD, MD.

17. Burial Date thereof 3-9-47

(month) (day) (year)

Cemetery or crematory PRESBYTERIAN

Location WASHIN ALEXANDRIA, VA.

18. Funeral director CHAMBERS (577-1125 S.E.)

Address WASHINGTON D.C.

19. Marshal 1947

(Date rec'd by registrar)

Odey Price

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County CHARLES

City or town INDIAN HEAD

(If outside city or town limits, write RURAL and give nearest town)

Street No. 12 EARL ROAD

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7 1947 at 1158 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-5 1947 to 3-7 1947

and that I last saw her alive on 3-7 1947

Immediate cause of death

* METASTATIC CARCINOMA
(RESPIRATORY ENDCRACHMENT)Due to Primary carcinoma of breast. Cancer.
Metastatic spread to the lung tissue.

Due to Also, cerebral metastases.

DURATION

6 YEARS

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations CARCINOMA

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

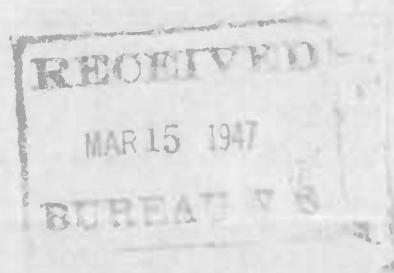
Injured at work?

23. SIGNATURE

Frederic W. Reichardt M.D.

M. D. or other

Address Indian Head Md. Date signed 7-8-47



2-35

MARYLAND

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

02746

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICAL CAUSE OF DEATH in plain terms, so that it may be properly classified. Important. See instructions on back of certificate.

PLACE OF DEATH

Charles

CERTIFICATE OF DEATH

County of

Registration
District No.

Township of

or
Borough ofor
City ofPrimary Registration
District No.

File No.

Registered No.

2. FULL NAME

Regina Greenfield Mable

[If death occurred in a
Hospital or Institution
give its NAME instead
of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED
OR DIVORCED (write the word)

F

Col.

Widowed

5a. If married, widowed, or divorced
HUSBAND OF
(or) WIFE OF

6. DATE OF BIRTH (month, day, and year)

? 1920

7. AGE

Years

Months

Days

IF LESS than
1 day, hrs.
or, min.

27

8. OCCUPATION OF DECEASED

Housework

9. BIRTHPLACE (city or town)

(State or country)

Malcolm, Md.

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (city or town)

(State or country)

MAIDEN

12. NAME OF MOTHER

Eva Greenfield

13. BIRTHPLACE OF MOTHER (city or town)

(State or country)

Malcolm, Md.

14.

Informant

Lavina Greenfield

(Address)

15.

Filed

Malcolm, Md.

11-3184

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 25 1947
(Month) (Day) (Year)

17.

I HEREBY CERTIFY, That I attended deceased from

....., 19....., to 19.....,

that I last saw her alive on Feb. 21 1947

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary & circulatory
collapse due to
Plethora pulmonalis

(duration) 1 yrs. 2 mos. 7 ds.

CONTRIBUTORY

(SECONDARY)

Emaciation &
Anorexia

(duration) yrs. mos. ds.

18. Where was disease contracted

If not at place of death?

Old an operation preceded death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

John L. Laffin

March 26 1947 (Address)

M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, Cremation or Removal

St. Peter's, Nedorf, Md.

20. UNDERTAKER

Hunt & Ryan

DATE OF BURIAL

3/26 1947

ADDRESS

Nedorf, Md.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of ~~gestation~~ ~~in months~~.

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day Laborer, Farm laborer, Laborer—Coal mine etc.* Women at home who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever write *None*.

Statement of cause of death.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term of

APR 2 1947

the same diseases. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid-Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc., carcinoma, Sarcoma, etc.* of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease, Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example. *Measles* (disease causing death), 29 ds; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraæmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septichæmia" "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such if impossible to determine definitely. Examples: *Accidental drowning: Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—Probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory."

Space for additional information by physician

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

02747

106

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

Charles
Lindan Head 012
(If outside city or town limits, write RURAL and give nearest town)
4 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Ellen Neale

4. Sex

Female

5. Color or race

Col.

6. (c) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

March 26, 1947

8. AGE:

Years

Months

Days

If less than one day

4 hrs. min.

9. Birthplace

(Town, county, and state)

Lindan Head 012

10. Usual occupation

Infant

11. Industry or business

(Town, county, and state)

James E. Neale

12. Name

(Town, county, and state)

La Plata 012

13. Birthplace

(Town, county, and state)

Waldesla Johnson

14. Maiden name

(Town, county, and state)

Baltimore 012

15. Birthplace

(Town, county, and state)

James E. Neale

16. Informant

(Town, county, and state)

La Plata 012

Address

(Town, county, and state)

La Plata 012

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof March 31, 1947

(month) (day) (year)

Cemetery or crematory

(Town, county, and state)

Sacred Heart

La Plata 012

Location

(Town, county, and state)

La Plata 012

18. Funeral director

(Town, county, and state)

James E. Neale

Address

(Town, county, and state)

La Plata 012

19. 3 - 31 1947

(Date rec'd by registrar)

Odey Price

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Charles

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 30 1947 5:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on

19.

Immediate cause of death

Atelectasis

Due to

Due to

Prematurity

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Lamb. Susan B. M. D. or other

Address

Lindan Head 012 Date signed 3/30/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

CERTIFICATE OF DEATH

02748

Reg. Dist. No. 100

1. PLACE OF DEATH:

Charles St. at
County.....

Benedict

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

George Vincent Parker

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

6. (b) Name of husband or wife.....

7. Birth date of
deceased (mo., day, yr.)

Nov. 24 1878

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

68

3

20

..... hrs. min.

9. Birthplace.....

Charles Co. Md

(Town, county, and state)

10. Usual occupation.....

Clerk

11. Industry or business.....

Grocery Store

MOTHER FATHER

12. Name.....

George V. Parker

13. Birthplace.....

Prince Geo. Co., Md

14. Maiden name.....

Sarah C. Roach

15. Birthplace.....

Charles Co. Md

16. Informant.....

Mary Joe Duke

Address.....

Benedict, Md,

Burial

Date thereof..... 3-17-47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

St. Mary's Cemetery

Location.....

Bryantown, Md

18. Funeral director.....

Elmer M. Quade

Address.....

Hughesville, Md

19. Date rec'd by registrar.....

19

Julia Pacey

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

Charles

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

March 14 47

19

at

8 P.M.

2D. DATE OF DEATH.....

Feb

1947

to March 14 1947

and that I last saw him alive on March 14 1947

Immediate cause of death Pulmonary-circulatory collapse (peripheral)

DURATION

Due to Bilateral lung lesions

Due to Tuberculosis, pulmonary bilateral

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Alfred R. Lapan, M.D.

M. D. or other

Address.....

Aquia Co., Md

Date signed.....

Mar 15 1947

RECEIVED

MAR 19 1947

BUREAU OF INVESTIGATION

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1372

02749

CERTIFICATE OF DEATH

Reg. Dist. No. 105

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County

City or town

Charles
White Plains MD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Florence Rabey

4. Sex

F.

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Julian

7. Birth date of deceased (mo., day, yr.)

Aug 15 - 1871

6. (c) If alive, give age years

8. AGE:

75

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Chas Co MD

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

Cray Rabey

12. Name

Chas Co MD

13. Birthplace

Chas Co MD

14. Maiden name

Mycrover

15. Birthplace

Chas Co MD

16. Informant

Mrs Florence Perry

Address

White Plains MD

17. Burial

Date thereof 3-24-47

(Burial, cremation, or removal. Why?)

Cemetery or crematory

St Paul Perry

Location

Waedoy MD

18. Funeral director

J. Smith & Sons

Address

Waedoy MD

19. Date rec'd by registrar

3-24

1947

M. D. or other

Signature

Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD

County Chas

City or town White Plains MD

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 22 1947 at 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1938 to 1947

and that I last saw h. ev. alive on 3/1/22 1947

Immediate cause of death

Myocardial

A pop lesion

Cardio - Vasculare

Vascular Disease

Due to

Density

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

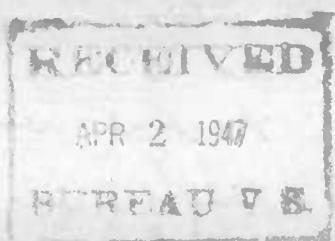
Means of injury

Injured at work

23. SIGNATURE

M. D. or other

Address Edward M. M.D. Date signed 3/23/47



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

02750

CERTIFICATE OF DEATH

Reg. Dist. No. 1000

1. PLACE OF DEATH:

County Charles
 City or town Bryantown Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 + yearsHospital, institution, or street address where death occurred: homeHow long in hospital or institution? —

3. (a) FULL NAME

LOUIS HENRY STEFFENS

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

MARIE

7. Birth date of deceased (mo., day, yr.)

6/2/916. (c) If alive, give age 51 years

8. AGE:

55

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Duluth, Minnesota

(Town, county, and state)

10. Usual occupation

Surveyor

11. Industry or business

12. Name DIETRICH H. STEFFENS13. Birthplace WHITESTONE LONG ISLAND, N.Y.14. Maiden name MARIE A. STEFFENS15. Birthplace GERMANY16. Informant SON. DIETRICH STEPHEN STEFFENSAddress BRYANTOWN, MD.17. Burial Bryantown Date thereof 3-20-47(Burial, cremation, or removal. Which) 5 + Pauls LutheranCemetery or crematory 6 Hartnett Hall RdLocation Hartnett & Bryon18. Funeral director Waldorf FunAddress Waldorf Fun19. (Date rec'd by registrar) 19 Permit issued by La Plata Registrar 4

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CharlesCity or town Bryantown (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war World War I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1947 at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 24 1946 to March 17 1947and that I last saw him alive on March 17 1947

Immediate cause of death

Generalized Carcinomatosis
UremiaDue to Malignant Melanoma

DURATION

6 1/2 mos

Due to...

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

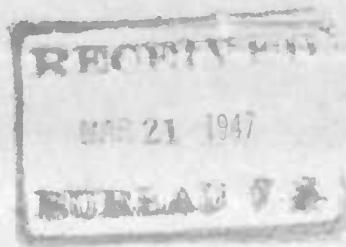
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Harren Jarboe, M.D. M. D. or otherAddress La Plata, Md. Date signed 3/18/47



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2020

02751

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Phys. Mem. Hosp. LaPlata Md.

How long in hospital or institution?

3-18-47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Chas.

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

None

3. (a) FULL NAME

James Samuel Turner

4. Sex

M

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife.....

Ethel Jane Montgomery

7. Birth date of deceased (mo., day, yr.)

June 11, 1867

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

11 less than one day

. hrs. . min.

9. Birthplace.....

Chas. Co. Md.

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business.....

12. Name.....

Edward Turner

13. Birthplace.....

?

14. Maiden name.....

Lomas

15. Birthplace.....

16. Informant.....

Address

3015-5 1/2 NE + 1900 BST A E DC

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

Trinity

Arltaville

18. Funeral director.....

Address

Shane Lee Qualls

Highsville Md

19. (Date rec'd by registrar)

3/21/47

1947

Julia H. Pauly

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

3-20 1947 at 5:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1945 to 3-20 1947

and that I last saw him alive on 3-20 1947

Immediate cause of death.....

Cerebral Hemorrhage

DURATION

9-10-46

12-1-46

3-10-47

Due to.....

Hypertension

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

B. Redden M. D. or other

Address..... LaPlata, Md. Date signed 3-20-47

RECEIVED

MAR 25 1947

BUREAU OF INVESTIGATION

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1702

02752

CERTIFICATE OF DEATH

Reg. Dist. No. 1004

1. PLACE OF DEATH:

County..... Charles

City or town..... La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 1/2 days

Hospital, institution, or street address where death occurred: Physician's Memorial Hospital

How long in hospital or institution?..... 2 1/2 days

3. (a) FULL NAME

W.
Guy Willey

4. Sex

5. Color or race

b. (a) Single, married, widowed, or divorced

Male

White

Divorced

6. (b) Name of husband or wife

Estrella Phillips

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... 51 years
1894

8. AGE:

Years

Months

Days

If less than one day

53

hrs.

min.

9. Birthplace

Bishop's Head, Md.

(Town, county, and state)

10. Usual occupation

Deckhand

11. Industry or business

Power Cranes

MOTHER/FATHER

12. Name..... Louis Willey

13. Birthplace

Bishop's Head, Md.

14. Maiden name

Alice Robinson

15. Birthplace

Bishop's Head, Md.

16. Informant

Norman Willey (son)

Address

Cambridge, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... 3/7/47

(month) (day) (year)

Cemetery or crematory

Location

Cambridge, Maryland

Burritt & Ryton

18. Funeral director

Address

Waertor, Md.

Julia H. Pacey

19. (Date rec'd by registrar)

19.....

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County..... Dorchester

City or town..... Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 4, 1947, at 1:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

on March 4, 1947, to

and that I saw him alive on March 4, 1947.

Immediate cause of death.....

Pulmonary edema +
mediastinal shock (flutter)

Due to..... Crushed chest

Due to..... Auto accident

Other conditions..... Fracture left leg
all intra-abdominal contusions.
(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of..... 3-2-47

Where did injury occur?..... Newberg, Charles, Md.

(City or town) (County) (State)

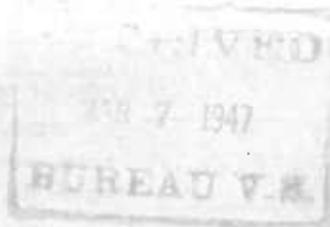
Injured at home, farm, industry, public place (where?)..... State Rd. 301

Means of injury..... Cut across over Deputy Police Commissioner

Injured at work? No

Address..... 2 Plaza Dr. M. D. or other

Date signed 3-4-47



1-35-